

FILED DEC 9 1944
149

State File No. _____
Registrar's No. 4771

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Willows Hospital-2929 Main St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days 2 hrs
(Specify whether years, months or days) same

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 42
(c) City or town Kansas City Mo 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2929 Main St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME Nancy Compagno

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced babe
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 5 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
14 2 hr -- min.

9. Birthplace Kansas City Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name -----
13. Birthplace -----
(City, town, or county) (State or foreign country)
14. Maiden name Rose Compagno
15. Birthplace Alton Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant A.U. Dysart R.N.

(b) Address 2929 Main St

17. (a) Burial (b) Date thereof Nov 25th 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Clyar Funeral Home

(b) Address 1800 Linwood

19. (a) 11-27-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19th
year 1944 hour _____ minute 10:55 A.M.

21. I hereby certify that I attended the deceased from Nov 5, 1944 to Nov 19, 1944;
that I last saw him alive on Nov 19 1944, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Heart Disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1572

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature H. Sawyer (M. D. or other) _____
Address 315 Alameda Road Date signed 11/21/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} ~~was~~ embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Chas E. Wilks

Licensed Embalmer No 2644

P. O. Address 1800 Pinewood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.